STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185242	A. BUILDING _____ B. WING _____	C 07/23/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR CARE CENTER	125 STERLING WAY MOUNT STERLING, KY 40353

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A Recertification/Abbreviated Survey was conducted on 07/20 -23/10 and a Life Safety Code Survey was conducted on 07/20/10. Deficiencies were cited with the highest scope and severity of a "F". ARO #KY00014926 was substantiated with no deficiencies cited. ARO #KY00015054 was substantiated without deficiencies. ARO #KY00015055 was unsubstantiated with no deficiencies.	F 000	The following constitutes the facility's response to the findings of the Department for Health Services and does not constitute an admission of the facts alleged or conclusions set forth on the summary statement of deficiencies.	
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure resident environment remains as free from accident hazards as possible. During the environmental tour two (2) spray bottles of hazardous chemicals were observed in an unlocked cabinet in the Sterling Way Unit shower room. The findings include: Observations on 07/22/10 at 11:50 AM during the environmental tour, revealed a cabinet in the Sterling Way Unit shower room, a common resident area to be unlocked and contained two (2) bottles of cleaning agents. Further observation	F 323	This plan of correction is prepared as required by the provisions of the Health Safety code, 42 CFR and constitutes the facility's written credible allegation of compliance. F323 No residents were harmed by the alleged deficient practice. The cabinet was secured and all other areas checked to ensure no other unlocked cabinets were present. New keys were made for cabinets and secured in shower areas. Nursing and Housekeeping Staff in-servicing was started on 7/26/10 by Environmental Service Director and will continue through 8/17/10 on keeping chemicals locked and secured at all times.	

RECEIVED
AUG 30 2010
BY:

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Rebecca Cooley — TITLE: Administrator — (X6) DATE: 8-30-10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 323	Continued From page 1 revealed the two (2) cleaning agents stored in the cabinet contained hazardous warning labels. The cleaning agents were a spray bottle of Assurance HD spray and wipe, and a spray bottle of Arsenal RE-JUV-NAL. Review of the Material Safety Data Sheet (MSDS) for the Assurance spray revealed health hazard data which included: Eye irritant, respiratory risk, and harmful if swallowed. Emergency and First Aid immediately flush with water, do not induce vomiting if swallowed, "GET MEDICAL ATTENTION IMMEDIATELY". Review of the MSDS for the Arsenal RE-JUV-NAL revealed health hazard data which included: Eye irritant can produce permanent damage, skin irritant can be destructive to tissue, irritant to the respiratory system, and harmful if swallowed do not induce vomiting, give large volumes of water followed by milk. Contact Physician. Interview with the Director of Nursing (DON) on 07/23/10 at 2:40 PM revealed the staff were to keep cleaning chemicals in a secure area to prevent a resident from getting in to them. She further stated the cabinet wasn't locked because the lock was not working yesterday, and this was not reported to anyone to be repaired.	F 323	To ensure continued compliance – unit managers check lists will be updated to include checking chemical storage areas on units and they will be checked weekly for compliance. The facility QA nurse or designee will review nurses check lists to ensure process put into place is working monthly x 3 months and an audit will be added to the quarterly nursing QA tools to be reviewed by QA committee quarterly thereafter to ensure continued compliance..	8-18-10
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371	F371 No residents were harmed by alleged deficient practice.	

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F 371	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined the facility failed to prepare, distribute and serve food under sanitary conditions. Staff were observed not washing their hands properly during tray line service. The findings include: Observation of the noon meal on 07/21/10 at 12:08 PM revealed the Assistant Dietary Manager to unplug a fan with her gloves on, then started serving the dining room tray line without washing her hands. Further observation revealed her to dip soup into a bowl, pick up a towel from under the work station, wipe the side of the bowl and continue to serve the tray line, she did not wash her hands. Observation of Dietary Aide #3 on 07/21/10 at 12:45 PM revealed her to leave the dining room tray line to get requested thicken drinks. She held on to the kitchen door with her ungloved right hand as she entered the kitchen, she removed the thicken liquid drinks from the refrigerator, returned to the tray line and continued to serve up the food, picking up sliced bread with her bare hand, with no gloves. She did not wash her hands. Interview with the Assistant Dietary Manager on 07/21/10 at 1:15 PM revealed the facility procedures for hand washing was anytime you touch anything you should remove your gloves	F 371	Dietary Staff re-education completed on August 12, 2010 on proper hand washing and changing of gloves while serving foods and during preparation. Procedures are posted above hand sinks in dietary department. Handouts and verbal instruction given by Dietitian and Dietary Manager. The RD will complete monthly tray line audit to ensure compliance with hand washing procedures and changing of gloves. The facility will monitor the processes put into place through the facility QA process monthly x 3 months and the audit tools will be added to required audits for Dietary and reviewed quarterly thereafter by the QA committee.	08-13-10

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F 371	Continued From page 3 and wash your hands and reapply gloves. She further stated she knew better, and knew she should have washed her hands. Interview with Dietary Aide #3 on 07/21/10 at 1:20 PM revealed she was not aware she had touched the door. She further stated, "You get so caught up in everything, yes I should have washed my hands before going back to the tray line."	F 371		

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K 000	INITIAL COMMENTS A Life Safety Code survey was initiated and concluded on 07/20/10. The facility was found not to meet the minimal requirements with 42 Code of the Federal Regulations, Part 483.70. The highest scope and severity deficiency identified was a " F ".	K 000	The following constitutes the facility's response to the findings of the Department for Health Services and does not constitute an admission of the facts alleged or conclusions set forth on the summary statement of deficiencies. This plan of correction is prepared as required by the provisions of the Health Safety code, 42 CFR and constitutes the facility's written credible allegation of compliance.	
K 046 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1. This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure emergency battery operated lighting was tested according to NFPA standards. The findings include: Observation on 07/20/10 at 11:47 AM, revealed two (2) emergency battery operated lights at the front entrance of the facility would not operate when tested by maintenance personnel during the Life Safety Code Survey. These two lights were the only available lighting for the exit in the event of an emergency. Further observation during the Life Safety Code Survey revealed tow (2) additional emergency battery operated lights in the Glass Hall corridor that would not operate when tested by maintenance personnel. Interview on 07/20/10 at 11:47 AM, with the Environmental Services Director, revealed the facility did not perform any maintenance or testing of the emergency battery operated lights.	K 046	K 046 Exit lighting has been checked through out the facility and those found not to be working have been repaired or replaced. A maintenance schedule has been established for monthly checks to be completed and testing to be performed per regulation to ensure 90 minute, duration of each light by maintenance staff. This will be monitored by Environmental Services supervisor monthly and through the facility QA process.	8-15-10

RECEIVED
AUG 10 2010
BY:

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Rebecca Cooley — TITLE: Administrator — (X6) DATE: 8-10-10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 046	Continued From page 1 Reference: NFPA 101 (2000 edition) 7.9.3 Periodic Testing of Emergency Lighting Equipment. A functional test shall be conducted on every required emergency lighting system at 30-day intervals for not less than 30 seconds. An annual test shall be conducted on every required battery-powered emergency lighting system for not less than 11/2 hours. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. Exception: Self-testing/self-diagnostic, battery-operated emergency lighting equipment that automatically performs a test for not less than 30 seconds and diagnostic routine not less than once every 30 days and indicates failures by a status indicator shall be exempt from the 30-day functional test, provided that a visual inspection is performed at 30-day intervals.	K 046		
K 063 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems have an adequate and reliable water supply which provides continuous and automatic pressure. 9.7.1.1, NFPA 13 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure sprinkler heads could produce a clear and effective spray pattern according to NFPA standards.	K 063	K063 Cubicle curtains in rooms 129 and 131 were changed out with appropriate curtains that meet regulations. To ensure no other rooms contained curtains that did not meet regulations, each was checked and any room found to not have the correct curtains – were replaced with appropriate curtains. A back-up supply of cubicle curtains were ordered to replenish the inventory as the curtains that did not meet regulations has been removed from the facility. Environmental services director to ensure appropriate stock ordered in the future and will check prior to placing in inventory to ensure compliance.	

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K 063	Continued From page 2 The findings include: Observation on 07/20/10 at 2:23 PM, revealed two (2) cubicle curtains in resident room number 129 did not have mesh curtains meeting NFPA requirements. The cubicle curtains were observed to have a mesh weave smaller than ½ inch design. Further observation revealed resident room number 131 had one (1) set of cubicle curtains smaller than ½ inch. The Environmental Services Director was present during the observation. Interview on 07/20/10 at 2:23 PM, with the Environmental Services Director, revealed she was unaware of the curtains in the resident rooms. Reference: NFPA 101 (2000 edition) 19.3.5.5* Newly introduced cubicle curtains in sprinklered areas shall be installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. A.19.3.5.5 For the proper operation of sprinkler systems, cubicle curtains and sprinkler locations need to be coordinated. Improperly designed systems might obstruct the sprinkler spray from reaching the fire or might shield the heat from the sprinkler. Many options are available to the designer including, but not limited to, hanging the cubicle curtains 18 in. (46 cm) below the sprinkler deflector; using 1/2-in. (1.3-cm) diagonal mesh or a 70 percent open weave top panel that extends 18 in. (46 cm) below the sprinkler deflector; or designing the system to have a horizontal and minimum vertical distance that meets the requirements of NFPA 13,	K 063	No further action required at this time.	7-21-10

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K 063	Continued From page 3 Standard for the Installation of Sprinkler Systems. The test data that forms the basis of the NFPA 13 requirements is from fire tests with sprinkler discharge that penetrated a single privacy curtain.	K 063		
K 070 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Portable space heating devices are prohibited in all health care occupancies, except in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F. (100 degrees C) 19.7.8 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure unapproved portable space heaters were restricted from use inside the facility. The findings include: Observation on 07/20/10 at 11:37 AM, revealed the facility had a portable space heater in the office of the Environmental Services Director. The Director of Environmental Services was present during the observation. Interview on 07/20/10 at 11:39 AM, with the Director of Environmental Services, revealed the facility could not produce documentation that the portable space heaters heating element did not exceed 212 degrees Farenheit .	K 070	K070 Space Heater was removed from facility on 7/20/10 after being unable to locate appropriate paper work to ensure heating element did not exceed 212 degrees Fahrenheit. Other offices checked for space heaters, none identified. Housekeeping staff to monitor offices while cleaning for space heaters and report to maintenance supervisor if found. Housekeeping staff was in serviced on 7/20/10 Any office that contains a space heater will provide appropriate documentation to ensure regulations are met or they will not be allowed to remain in the facility. This process will be monitored by the facility QA process monthly for 3 months and quarterly thereafter.	7-21-10
K 130 SS=F	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786	K 130		

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K 130	Continued From page 4 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure single station smoke alarms were maintained according to NFPA standards. The findings include: Observation on 07/20/10 at 2:00 PM, revealed the facility had single station smoke alarms in all resident rooms. Interview on 07/20/10 at 2:00 PM, with the Environmental Services Director, revealed that the single station smoke alarms were put in place due to the facility thinking they were required. Further interview revealed the facility later learned the single station smoke alarms were not required and therefore they felt they were not required to provide maintenance or testing for the single station smoke alarms. The facility could not produce any records for maintenance of the single station smoke alarms. Reference: NFPA 101 (2000 edition) 4.6.12.2* Existing life safety features obvious to the public, if not required by the Code, shall be either maintained or removed.	K 130	K 130 Smoked detectors that are currently located in resident rooms that are not required by regulations will be removed.	8-15-10
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code, 9.1.2	K 147	K 147 Adapter was removed immediately from room 207 and family notified that use not allowed for medical equipment.	

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K 147	Continued From page 5 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure electrical needs were meet according to NFPA standards. The findings include: Observation on 07/20/10 at 2:26 PM, revealed that in Room 207 an oxygen concentrator was plugged into a multiplug power strip. The Environmental Services Director was present during the observation. Interview on 07/20/10 at 2:26 PM, with the Environmental Services Director, revealed she was unaware of why the oxygen concentrator was plugged into the multiplug adapter. Reference: NFPA 99, Chapter 3 Electrical Systems. 3-3.2.1.2 D 2. Minimum number of Receptacles. The number of receptacles shall be determined by the intended use of the patient care area. There shall be sufficient receptacles located so as to avoid the need for extension cords or multiple outlet adapters.	K 147	Other rooms were checked that contained medical equipment to ensure no others were present. Staff in-servicing to be completed by 8/6/10 on not plugging medical equipment into adapter plug. To ensure continued compliance rooms will be checked weekly by safety round schedule for medical equipment by QA nurse or designee. This will be monitored through the facility QA process monthly x 3 months and quarterly thereafter.	8-6-10